however, we do not think that seeing the glass half full equates with presenting "an unduly optimistic portrayal of American physicians' viewpoints." In fact, we would argue that up until this time, physicians and the media have painted an unduly pessimistic picture of what it is like to be a physician today. As a colleague recently wrote to us, "We tend to be louder wailing than laughing." The truth is that for most of us, the benefits of helping patients and having meaningful relationships with them continue to outweigh the hassles posed by challenges to our autonomy and professional satisfaction. We would rather savor the half glass of milk that remains than lament over the half glass that is missing.

It is encouraging that despite negative publicity about our profession, applications to medical schools continue to rise. Talented young persons, presented with a wide menu of fascinating and challenging careers, are opting for medicine in record numbers. Preliminary data from a survey of premedical students suggest that these applicants have realistic expectations of what a medical career would be like (J. Chuck, MD, P. Van Houten, PhD, Office of Career and Graduate School Services, University of California, Berkeley, unpublished data, 1993). In addition, a large number of established professionals continue to leave their jobs to become physicians. In interviewing this type of applicant to our medical school, we often hear comments like, "I want to help people on a one-on-one basis and to see the results of my efforts." We challenge practicing physicians to critically compare and contrast their current profession with others that they might have pursued or would consider pursuing in the future. We think most will conclude that, all things considered, the grass is greenest on our side of the fence where every patient interaction gives us the opportunity to help our fellow humans in an important and meaningful way.

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Are Performers Special Patients?

TO THE EDITOR: We wish to comment on the review, "Performing Arts Medicine," by Ostwald and colleagues in the January 1994 issue.[1] As primary care physicians, we appreciate this information because understanding the special problems of performers will enhance the accuracy of our diagnoses and increase the likelihood of rapid, appropriate therapy for our patients.

Unfortunately, the implication in the authors' discussion of upper respiratory tract illnesses and allergies among singers cannot go unchallenged. They discourage a wait-and-see approach and advocate quick intervention because of the level of anxiety that artists experience and because of the possibility of a canceled performance. We cannot agree that artists are entitled to more rapid or—allegedly—superior health care than our other patients who also face time off work or other equally good reasons to avoid the inconvenience of self-limited illness. All our patients deserve the best we have to offer each time we see them, independent of their livelihood.

We are disturbed by the authors' suggestion that we should use powerful broad-spectrum antibiotics to manage ailments that are almost entirely viral or allergic in origin. Is there evidence that performers respond better than other people when given a broad-spectrum antibiotic for a cold?

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REFERENCE

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Drs Ostwald, Baron, Byl, and Wilson Respond

TO THE EDITOR: We were happy to read the appreciative response to our recent article on performing arts medicine; however, Drs Kennedy and Shearn appear to have misinterpreted our comments regarding the care of vocal performers. Efficient and rapid treatment of a singer or actor does not imply that performing artists deserve superior health care. The approach is patient-specific, as it always should be with good medicine. We point out that singers and actors are in fact affected very differently by sinusitis or acute laryngitis than patients with another livelihood. Such conditions may not mean time off work for the latter, nor do throat problems necessarily imperil the career of a nonsinger.

Regarding comments about antibiotics, we mention in a general sense that amoxicillin clavulanate or cephalosporins are appropriate for some illnesses such as sinusitis and laryngopharyngitis, which are often bacterial. We did not intend to suggest that these medicines be used to treat a cold.

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Recurrent Nonsuppressible Secondary Hyperparathyroidism Following Subtotal Parathyroidectomy

TO THE EDITOR: We report a case of severe, recurrent, secondary hyperparathyroidism. Although subtotal parathyroidectomy is typically advocated for patients with uremia,[1] close postoperative surveillance is crucial: nonsuppressible secondary hyperparathyroidism is a potentially life-threatening condition in these patients.

Report of a Case

The patient, a 28-year-old woman, was transferred to

our hemodialysis center with refractory anemia, hypertension, and general aching. She began hemodialysis in 1980 for end-stage medullary sponge kidney disease. Over the next 13 years, the patient rejected three renal allografts and was treated with hemodialysis with fair metabolic control.

A subtotal (3½ gland) parathyroidectomy was done in 1987. Both native kidneys and all allografts were removed because of hypertension and complications of rejection.

Our evaluation confirmed the presence of hypertension resistant to the concurrent administration of hemodiafiltration, metoprolol tartrate, clonidine, nifedipine, and enalapril maleate. The hematocrit was 0.23 (23%), and transferrin saturation was 0.25 (25%). Despite a regimen of erythropoietin, 5,000 units intravenously three times a week, the patient remained anemic. The calcium-phosphorus product (milligrams per deciliter of calcium times milligrams per deciliter of phosphorus) was 50, but the serum alkaline phosphatase level was 762 U per liter (normal < 117), suggesting recurrent hyperparathyroidism. The serum intact-parathyroid hormone level was 5,576 pg per ml (1,360 pmol per liter; upper limits of normal, 54 pg per ml). Despite the intravenous administration of calcitriol, 2 μg per treatment, phosphate binding, phosphate restriction, and dialytic therapy for three months, the hyperparathyroidism was not suppressed.

Neck re-exploration revealed a 3.5-cm solitary parathyroid mass, which was resected. Histopathologic examination revealed parathyroid adenoma. Massive calcium supplementation was required—more than 250 grams cumulative dose of calcium gluconate and calcium carbonate—over the next several weeks to maintain normocalcemia. The patient required intensive care monitoring for severe neuromuscular, cardiovascular, and electrocardiographic complications of hypocalcemia.

The patient ultimately became stable on a regimen of calcitriol, 0.5 μg; calcium acetate, 1,300 mg; and calcium carbonate, 1,500 mg per day.

By four weeks after the operation, the patient's general aching abated, her blood pressure was 150/90 mm of mercury with low-dose nifedipine therapy plus hemodiafiltration, and her hematocrit value improved, implying a recovery of erythropoietin sensitivity. At three months and nine months after the operation, intact parathyroid hormone levels were less than 5 pg per ml, suggesting adequate removal of residual parathyroid tissue.

Comment

Severe, nonsuppressible secondary hyperparathyroidism recurred in this patient despite standard therapy. The remnant half of the original native parathyroid gland enlarged to a massive adenoma. A typical "hungry bone" syndrome[2(p1441)] occurred postoperatively, reflecting the severe preoperative hyperparathyroidism.

The patient's preoperative condition suggested erythropoietin resistance[3] associated with the osteosclerosis of secondary hyperparathyroidism. Refractory hypertension may have reflected vascular smooth muscle intracellular calcium overload.[4] This is likely, rather than erythropoietin-induced hypertension, because of easier blood pressure control after the parathyroidectomy.

Some remaining parathyroid hormone activity may help prevent osteomalacia in uremic patients,[5] so subtotal parathyroidectomy may be a first-line treatment. The central importance of anemia as a predictor of mortality, however,[6] and the potential of parathyroid hormone to cause erythropoietin resistance demand early surgical intervention with remnant parathyroidectomy when parathyroid disease recurs.

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The Editors are pleased to receive letters commenting on articles published in the journal in the past six months, as well as information or short case reports of interest to our readers. ALL MATERIAL SUBMITTED FOR CONSIDERATION MUST BE DOUBLE-SPACED. Letters NO LONGER THAN 500 WORDS are preferred. An original typescript and one copy should be submitted. All letters are published at the discretion of the Editors and subject to appropriate editing. Those of a scientific nature will be peer reviewed. Authors should include information regarding conflict of interest, when appropriate ("I warrant that I have no financial interest in the drugs, devices, or procedures described in this letter"). Most letters regarding a previously published article will be sent to the authors of the article for comment. Authors of accepted letters will have an opportunity to review the edited version before publication.